Exhibit 10

222A915984

INITIAL REPORT

Patient Name: Redacted

Date of Birth:

Date of Accident: 11/27/08

Initial Evaluation Date: 12/22/08

Claim Number: 22A915984

Insurance Company: State Farm

HISTORY OF CURRENT CONDITION

Date of Onset: 11/27/2008

Driver/ Passenger: (Driver circled)

Front Seat/ Back Seat: (Front Seat circled)

Airbag Deployment: Yes/ No (No circled)

Wearing Seatbelt: Yes/ No (No circled)

Type of Auto: Van/ Truck/ Sedan (Truck circled)

sitting at (L) light, want to make a (L) turn, saw a tow truck coming up from behind, did not slow down, gunned the car to get out of the way, tow truck hit back of drivers side of her car. followed tow truck back to yard, police were called. the next day she woke up not [illegible], could not move, while (L) side of body hurt. went to [illegible], Dr. [illegible], he has been treating her 3x week for 1 month

Type of Other Vehicle Involved: TOW TRUCK

Type of Collision: Front End/ Rear End/ Driver Side/ Passenger Side (Rear End circled)

Did Vehicle Hit anything Else after Collision? NO.

Primary Cause of Collision: tow truck driver said he did not see her.

Amount of Damage to Vehicle:

Body Injuries in Vehicle: Head on Steering Wheel/ Dashboard

Loss of Consciousness: no

Immediate Pain after Collision: Yes/ No/ Hours Later/ Next Day

Police Came to Scene: Yes/ No — met at township yard.

EMS came to scene: Yes/ No

Transportation to Hospital by Ambulance: Yes/ No

Anyone Other than Ambulance?

Emergency Room Treatment: Xrays/ CT Scan/ MRI/ Medicine/ Admitted/ Released/ Kept for Observation

Follow Up: Doctor's/ Testing — saw Chiro, pm. scanner, 4 weeks, PT even.

SYMPTOMS

Neck Pain/ Mid Back/ Low Back Pain — mostly of O.

Upper Extremity
Numbness/ Tingling/ Cold/ Right/ Left/ Both
Hands: Fingers:

Lower Extremity
Numbness/ Tingling/ Cold / Right/ Left/ Both
Buttocks/ Feet/ Toes

Headaches: (Yes)/No **Frequency:** everyday. **Duration:**
Dizziness/ Memory Loss:

Bowel/ Bladder Dysfxn:

Jaw Pain/ Tinnitus:

Head Pain/ Elbow Pain (R/L)/ Knee Pain(R/L)/ Ankle Pain (R/L) / Foot Pain (R/L)

Abdominal Pain: Location:

Chest Pain: Location:

PREVIOUS MEDICAL HISTORY

Asthma/ Diabetes/ Cancer/ Hypertension/ Heart Disease/ High Cholesterol:

Other:

Acute/ Chronic Medical Condition: see medical History Form

Previous Surgeries:

Previous Auto/ Work Accidents: **Year:** 2003

Treatment for Auto/ Work Accident: MRI/ CT/ Surgeries
- saw chiro for neck pr, (N) shld pr.

Resolved/ Not Resolved:

SOCIAL HISTORY

Married/ Divorced/ Widowed/ Single/ Separated

Children: 4 **Ages:** **Live At Home/ Away:** /

Smoke: Yes/(No)
How much:

Alcohol: Yes/(No)
How much:

Recreational Drugs: Yes/(No)
How much:

EMPLOYMENT

Employed at the time of Accident: (Yes)/ No

Currently Employed: (Yes)/ No

Date of Last Employment: current

Employer: Detroit media Partnership

Job Title: Newspaper delivery

Other:

PHYSICAL EXAM-APPEARANCE

Age: 55

Male/ (Female):

(White)/ Black:

Height: 5'4

Weight: 132

(Right Handed)/ Left Handed:

Difficulty Standing: (Yes)/ No
Notes:

Difficulty Getting In/Out of Chair/ Yes/ No
Notes:

NECK EXAM:

Neck Spasms/ Yes/ No Right Side/ Left Side/ Suboccipitals

ROM: ↓ Extension/ ↓ Flexion/ ↓ Right Lateral Flex / ↓ Left Lateral Flex/ ↓ Right/ Left Rotation more on Left.

Decrease Muscle Strength: Right/ Left Upper Extremity

Decrease Grip Strength: Right/ Left Upper Extremity

Cervical Compression Test: +/ -

Cervical Distraction Test: +/-

Shoulder Depression Test: +/-

Valsalva's Test: +

Palpatory Tenderness:

C-Spine: 1 2 3 4 5 6 7
T-Spine: 1 2 3 4 5 6 7 8 9 10 11 12

LUMBAR EXAM

Low Back Spasm: Yes/No Right Side/ Left Side

ROM: ↓ Extension/ ↓ Flexion/ ↓ Right Lateral Flex / ↓ Left Lateral Flex/ ↓ Right/ Left Rotation more on D

Decrease Muscle Strength: Right/ Left Lower Extremity

SLR: + on D

Palpatory Tenderness: L-Spine: 1 2 3 4 5

INITIAL IMPRESSION DIAGNOSIS

C/Sprain/ Ligament Injury

T/Sprain/Ligament Injury

L/Sprain/ Ligament Injury

C Radiculitis/Radiculopathy: R/L

L Radiculitis/ Radiculopathy: R/L

Headaches:

Dizziness: Y/N Tinnitus: Y/N

Shoulder Pain: R/L

Elbow Pain: R/L

Knee Pain: R/L

Ankle Pain: R/L

Foot Pain: R/L

DISABILITY

Employment: Yes/No

Restrictions:

Household: Yes/ No

Attendant Care:

Transportation: Yes/ No

RECOMMENDATIONS

X-rays: C/S T/S L/S - waiting from chiro for x-rays

Back School:

Home Treatment (ice, heat):

Back Support:

Neck Support:

Manipulation: C/S T/S L/S

Moist Hot Packs: C/S T/S L/S

Ice Packs: C/S T/S L/S

Therapeutic Exercises: Williams/Mackenzie Exercises/ Shoulder Shrugs/ Shoulder Squeezes/ Wall Walks (shoulder)/ E/S Flex-Ext-Rot-Lat Flex

Further Diagnostic Tests: yes — MRI

GOALS

Decrease Pain: ✓

Increase Pain Mobility: ✓

Increase Strength: ✓

Restore Activities of Daily Living: ✓

Initiation of Independent Home Exercises Program: ✓

PROGNOSIS

Good/ Guarded/ Poor:

Will Depend on Further Testing: ✓

Will Depend on Further Treatment: ✓

Awaiting Test Results:

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON IL 61702-2361

HEALTH INSURANCE CLAIM FORM

2

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
[ ] (Medicare #) [ ] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [X] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 22A915984

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT or PREVIOUS): [ ] YES [X] NO
b. AUTO ACCIDENT? PLACE (State): [ ] YES [X] NO
c. OTHER ACCIDENT? [ ] YES [X] NO

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE
a. INSURED'S DATE OF BIRTH: Redacted SEX: M [ ] F [X]
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NUMBER: STATE FARM INSURANCE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO If yes, return to and complete item 9 a-d.

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: BCBSM

10d. RESERVED FOR LOCAL USE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 01 / 05 / 2009

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE: 12 22 2008

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: $0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 839 06
2. 839 21
3. 839 20
4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From	To	B Place of Service	C EMG	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I I.D. QUAL	J RENDERING PROVIDER ID. #
12 22 08	12 22 08	11		99205		1	125.00	1		NPI	1013964451
12 23 08	12 23 08	11		97010	59	1	35.00	1		NPI	1013964451
12 23 08	12 23 08	11		97012	59	1	50.00	1		NPI	1013964451
12 23 08	12 23 08	11		98941		1,2,3	60.00	1		NPI	1013964451

25. FEDERAL TAX I.D. NUMBER: 205918486 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 00000953

27. ACCEPT ASSIGNMENT? [X] YES [ ] NO

28. TOTAL CHARGE: $270.00

29. AMOUNT PAID:

30. BALANCE DUE: $270.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SCOTT ZACK
SIGNED DC 01/05/2009

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
UNIVERSAL HEALTH GROUP, INC.
8191 N. WAYNE ROAD
WESTLAND MI 48185
1588832653

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE #
UNIVERSAL HEALTH GROUP, INC.
5761 WEST MAPLE ROAD
WEST BLOOMFIELD MI 48322 734 722-1500
1588832653

whcfa150

PLEASE PRINT OR TYPE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record," published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

22-A974-715

INITIAL REPORT

Patient Name: Redacted

Date of Birth:

Date of Accident: 4/4/09

Initial Evaluation Date: 4/13/09

Claim Number: 22A974715

Insurance Company: State Farm

HISTORY OF CURRENT CONDITION

Date of Onset: 4-4-09

Pt. DRIVING AT INTERSECTION / MICHIGAN AVE, AT A RED LIGHT, WAS REAR-ENDED BY UNKNOWN DRIVER, WHICH CAUSED HER TO HIT CAR INFRONT OF HER. CAR DIDN'T HIT HER, FELT SCARE, BUT WAS CONSIST. WENT TO POLICE STATION MADE A REPORT, WENT HOME, WAS IN PAIN. WOKE UP NEXT DAY IN PAIN, WENT TO ER WAS TREATED. X-RAY / CT SCAN PERFORM, THEN RELEASED.

Driver/ Passenger:

Front Seat/ Back Seat:

Airbag Deployment: Yes/ No

Wearing Seatbelt: Yes/ No

Type of Auto: Van/Truck/Sedan

Type of Other Vehicle Involved:

Type of Collision: Front End/ Rear End/ Driver Side/ Passenger Side

Did Vehicle Hit anything Else after Collision? CAR IN FRONT OF HER.

Primary Cause of Collision: Rear-ended.

Amount of Damage to Vehicle: UNKNOWN

Body Injuries in Vehicle: Head on Steering Wheel/ Dashboard

Loss of Consciousness: NO

Immediate Pain after Collision: (Yes)/ No/ Hours Later/ Next Day

Police Came to Scene: Yes/(No) - went to station to make report

EMS came to scene: Yes/(No)

Transportation to Hospital by Ambulance: Yes/(No)

Anyone Other than Ambulance?

went to St. Joes own after hospital DID;

Emergency Room Treatment: (X-rays)/(CT Scan)/ MRI/(Medicine)/ Admitted/ Released/ Kept for Observation

Follow Up: Doctor's/ Testing NONE

SYMPTOMS

(Neck Pain)/(Mid Back)/(Low Back Pain)

Upper Extremity
(Numbness)/(Tingling)/ Cold/ Right/(Left) Both
Hands: Fingers!

Lower Extremity
Numbness/ Tingling/ Cold / Right/ Left/ Both
Buttocks/ Feet/ Toes

Headaches: Yes/No **Frequency:** **Duration:**
Dizziness/ Memory Loss:

Bowel/ Bladder Dysfxn:

Jaw Pain/ Tinnitus:

Head Pain/ Elbow Pain (R/L)/ Knee Pain(R/L)/ Ankle Pain (R/L) / Foot Pain (R/L)
SHOULDER PAIN (L)

Abdominal Pain: Location:

Chest Pain: Location:

PREVIOUS MEDICAL HISTORY

Asthma/ Diabetes/ Cancer/ Hypertension/ Heart Disease/ High Cholesterol:

Other:

Acute/ Chronic Medical Condition:

Previous Surgeries: HERNIA – bym ago.
Brain hemorrh.

Previous Auto/ Work Accidents: NONE **Year:**

Treatment for Auto/ Work Accident: MRI/ CT/ Surgeries

Resolved/ Not Resolved:

SOCIAL HISTORY

Married/ Divorced/ Widowed/ (Single) Separated

Children: Ø **Ages:** **Live At Home/ Away:**

Smoke: Yes/(No)
How much:

Alcohol: Yes/(No)
How much:

Recreational Drugs: Yes/(No)
How much:

EMPLOYMENT

Employed at the time of Accident: Yes/(No)

Currently Employed: Yes/(No)

Date of Last Employment: NOVEMBER 08'

Employer: PF CHANGS

Job Title: SERVER

Other:

PHYSICAL EXAM-APPEARANCE

Age: 25

Male/(Female)

White/(Black)

Height: 5'5"

Weight: 120

Right Handed/(Left Handed)

Difficulty Standing: (Yes)/No
Notes:

Difficulty Getting In/Out of Chair: Yes/ No
Notes:

NECK EXAM:

Neck Spasms: Yes/ No Right Side/ Left Side/ Suboccipitals

ROM: Extension/ Flexion/ Right Lateral Flex/ Left Lateral Flex/ Right/ Left Rotation

Decrease Muscle Strength: Right/ Left Upper Extremity

Decrease Grip Strength: Right/ Left Upper Extremity

Cervical Compression Test: +/-

Cervical Distraction Test: +/-

Shoulder Depression Test: +/-

Valsalva's Test: +/-

Palpatory Tenderness:

C-Spine: 1 2 3 4 5 6 7

T-Spine: 1 2 3 4 5 6 7 8 9 10 11 12

LUMBAR EXAM

Low Back Spasm: Yes/ No Right Side/ Left Side

ROM: Extension/ Flexion/ Right Lateral Flex/ Left Lateral Flex/ Right/ Left Rotation

Decrease Muscle Strength: Right/ Left Lower Extremity

SLR: +/- R+L Pain on R

Palpatory Tenderness: L-Spine: 1 2 3 4 5

INITIAL IMPRESSION DIAGNOSIS

C/Sprain/Ligament Injury

T/Sprain/Ligament Injury

L/Sprain/Ligament Injury

C Radiculitis/Radiculopathy: R/L

L Radiculitis/ Radiculopathy: R/L

Headaches: Y/N

Dizziness: Y/N Tinnitus: Y/N

Shoulder Pain: R/L

Elbow Pain: R/L

Knee Pain: R/L

Ankle Pain: R/L

Foot Pain: R/L

DISABILITY

Employment: Yes/ No

Restrictions:

Household: Yes/ No

Attendant Care:

Transporsation: Yes/ No

RECOMMENDATIONS

X-rays: C/S T/S L/S

Back School:

Home Treatment (ice, heat):

Back Support:

Neck Support:

Manipulation: (C/S) (T/S) (L/S)

Moist Hot Packs: (C/S) (T/S) (L/S)

Ice Packs: C/S T/S L/S

Therapeutic Exercises: Williams/ Mackenzie Exercises/ Shoulder Shrugs/ Shoulder Squeezes/ Wall Walks (shoulder)/ E/S Flex-Ext-Rot-Lat Flex

Further Diagnostic Tests: TO R/O HNP

GOALS

Decrease Pain: X

Increase Pain Mobility: X

Increase Strength: X

Restore Activities of Daily Living: X

Initiation of Independent Home Exercises Program: X

PROGNOSIS

Good/ (Guarded)/ Poor:

Will Depend on Further Testing: X

Will Depend on Further Treatment: X

Awaiting Test Results: HOSPITAL X-RAY
HYGIENE CAT SCAN

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON IL 61702-2361

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER ☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) [X] (SSN or ID) ☐ (SSN) ☐ (ID)			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 22A974715
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted	3. PATIENT'S BIRTH DATE SEX Redacted M ☐ F [X]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted
	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse ☐ Child ☐ Other ☐		
	8. PATIENT STATUS Single [X] Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT or PREVIOUS) ☐ YES [X] NO		a. INSURED'S DATE OF BIRTH SEX Redacted M ☐ F [X]
b. OTHER INSURED'S DATE OF BIRTH SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☐ YES [X] NO		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES [X] NO		c. INSURANCE PLAN NAME OR PROGRAM NUMBER STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES [X] NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 04 / 15 / 2009

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE 04 13 2009	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. 17b. NPI	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES ☐ YES [X] NO $0.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 847 0 3. 847 2 2. 847 1 4. 723 4		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From	To	B Place of Service	C EMG	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	J I.D. QUAL.	J RENDERING PROVIDER ID. #
04 13 09	04 13 09	11		99205		1	125.00	1		NPI	1013964451

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
205918486 ☐ [X]	00001029	[X] YES ☐ NO	$125.00		$125.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE #
SCOTT ZACK SIGNED DC 04/15/2009	UNIVERSAL HEALTH GROUP, INC. 8191 N. WAYNE ROAD WESTLAND MI 48185 1588832653	UNIVERSAL HEALTH GROUP, INC. 5761 WEST MAPLE ROAD WEST BLOOMFIELD MI 48322 734 722-1500 1588832653

whcfa150

PLEASE PRINT OR TYPE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

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22B040575

RT

Redacted

Patient Name:

Date of Birth:

Date of Accident: 9-22-09

Initial Evaluation Date: 10-1-09

Claim Number:

Insurance Company:

HISTORY OF CURRENT CONDITION

Date of Onset: 9/22/09

Driver/ Passenger:

Front Seat/ Back Seat:

Airbag Deployment: Yes/ No

Wearing Seatbelt: Yes/ No

Type of Auto: Van/Truck/Sedan AUTO

Type of Other Vehicle Involved: AUTO

Type of Collision: Front End/ Rear End/ Driver Side/ Passenger Side
2 Cars.

Did Vehicle Hit anything Else after Collision? NO.

Primary Cause of Collision: other car turned into pt hit driver side rear

Amount of Damage to Vehicle:
Approx $3500

Body Injuries In Vehicle: Head on Steering Wheel/ Dashboard
HBD hit steering wheel
(L) side head hit door frame
Loss of Consciousness:
NO, DIZZY

Immediate Pain after Collision: Yes/ (No) Hours Later/ Next Day
3 days later.

Police Came to Scene: (Yes) No

EMS came to scene: Yes/ (No)

Transportation to Hospital by Ambulance: Yes/ No —

Anyone Other than Ambulance? —

Emergency Room Treatment: Xrays/ CT Scan/ MRI/ Medicine/ Admitted/ Released/ Kept for Observation —

Follow Up: Doctor's/ Testing — PT TMJ Mice at home
Notices pain getting worse

SYMPTOMS

Neck Pain/ Mid Back/ Low Back Pain

Upper Extremity
Numbness/ Tingling/ Cold/ Right/ Left/ Both
Hands/ Fingers: (L)

Lower Extremity
Numbness/ Tingling/ Cold / Right/ Left/ Both
Buttocks/ Feet/ Toes
Pain into knees

(1) LFT SI
LFT side hip
(2) LFT side head
(3) sharp pains (L) arm
in hand
(4) stiff neck.
(5) sharp pain into knees
(6) HBD spasms

Headaches: Yes/No Frequency: PRN Duration: CONST

Dizziness/ Memory Loss:

Bowel/ Bladder Dysfxn:

Jaw Pain/ Tinnitus:

Head Pain/ Elbow Pain (R/L)/ Knee Pain(R/L)/ Ankle Pain (R/L) / Foot Pain (R/L)

Abdominal Pain: Location: SPASM

Chest Pain: Location:

PREVIOUS MEDICAL HISTORY

Asthma/ Diabetes/ Cancer/ Hypertension/ Heart Disease/ High Cholesterol:

Other:

Acute/ Chronic Medical Condition:

Previous Surgeries: Hysterectomy, RT BREAST LUMP, GALL BLADDER

Previous Auto/ Work Accidents: Year:
SLIP / FALL 2003 INJURED RT D/S / SHOULDER

Treatment for Auto/ Work Accident: MRI/ CT/ Surgeries

—

Resolved/ Not Resolved: —

SOCIAL HISTORY

Married/ Divorced/ Widowed/ Single/ Separated

Children:	Ages:	Live At Home/ Away:
		LIVES W/ HUSBAND +
	3	18 YR. OLD DAUGHTER

Smoke: Yes/ No
How much: 1 pack.

Alcohol: Yes/ No
How much:

Recreational Drugs: Yes/No
How much:

EMPLOYMENT

Employed at the time of Accident: Yes/ No

Currently Employed: Yes/ No HAS NOT Returned to work since ACCID.

Date of Last Employment:

Employer: NAT. Council on Alcohol + Drug Dependency

Job Title: Prevention specialist

Other: Counseling.

PHYSICAL EXAM-APPEARANCE

Age: 56

Male/ Female:

White/ Black:

Height: 5'3

Weight: 152

Right Handed/ Left Handed:

Difficulty Standing: Yes/ No
Notes:

Difficulty Getting In/Out of Chair: Yes/ No
Notes:

NECK EXAM:

Neck Spasms: Yes/ No Right Side/Left Side/ Suboccipitals

ROM: ↓ Extension/ ↓Flexion/ ↓Right Lateral Flex / ↓Left Lateral Flex/ ↓Right/ Left Rotation

↑ PAIN IN NECK AT MID ROM ALL DIRECTIONS

Decrease Muscle Strength: Right/ Left Upper Extremity

Decrease Grip Strength: Right/ Left Upper Extremity

Cervical Compression Test: +/-

Cervical Distraction Test: +/-

Shoulder Depression Test: +/-

Valsalva's Test: +/-

Palpatory Tenderness:

C-Spine: 1 2 3 4 5 6 7
T-Spine: 1 2 3 4 5 6 7 8 9 10 11 12

LUMBAR EXAM

Low Back Spasm: Yes/No Right Side/Left Side

ROM: ↓ Extension/ ↓Flexion/ ↓Right Lateral Flex / ↓Left Lateral Flex/ ↓Right/ Left Rotation

Decrease Muscle Strength: Right/ Left Lower Extremity

SLR: +/-

Palpatory Tenderness: L-Spine: 1 2 3 4 5 SI

SCIATIC PAIN

INITIAL IMPRESSION DIAGNOSIS

C/Sprain/ Ligament Injury

T/Sprain/Ligament Injury

L/Sprain/ Ligament Injury

C Radiculitis/Radiculopathy: R/L

L Radiculitis/ Radiculopathy: R/L

Headaches:

Dizziness: Y/N Tinnitus: Y/N

Shoulder Pain: R/L

Elbow Pain: R/L

Knee Pain: R/L

Ankle Pain: R/L

Foot Pain: R/L

DISABILITY

Employment: Yes/ No

Restrictions:

Household: Yes/ No

Attendant Care:

Transportation: Yes/ No

RECOMMENDATIONS

X-rays: C/S T/S L/S ZV -

Back School:

Home Treatment (ice, heat): AS NEEDED AT HOME

Back Support:

Neck Support:

Manipulation: C/S T/S L/S

Moist Hot Packs: C/S T/S L/S

Ice Packs: C/S T/S L/S

Therapeutic Exercises: Williams/ Mackenzie Exercises/ Shoulder Shrugs/ Shoulder Squeezes/ Wall Walks (shoulder)/ E/S Flex-Ext-Rot-Lat Flex

Further Diagnostic Tests:

GOALS

Decrease Pain:

Increase Pain Mobility:

Increase Strength:

Restore Activities of Daily Living:

Initiation of Independent Home Exercises Program:

PROGNOSIS

Good/ Guarded/ Poor:

Will Depend on Further Testing:

Will Depend on Further Treatment:

Awaiting Test Results:

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON IL 61702-2361

HEALTH INSURANCE CLAIM FORM

2

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) [X] (SSN or ID) ☐ (SSN) ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
22B040575

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Redacted

3. PATIENT'S BIRTH DATE SEX
Redacted M ☐ F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Redacted

6. PATIENT RELATIONSHIP TO INSURED
Self [X] Spouse ☐ Child ☐ Other ☐

8. PATIENT STATUS
Single ☐ Married [X] Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT or PREVIOUS) ☐ YES [X] NO
b. AUTO ACCIDENT? PLACE (State) ☐ YES [X] NO
c. OTHER ACCIDENT? ☐ YES [X] NO

11. INSURED'S POLICY GROUP OR FECA NUMBER
NONE

a. INSURED'S DATE OF BIRTH SEX
Redacted M ☐ F [X]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NUMBER
STATE FARM INSURANCE

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
TOTAL HEALTH CARE USA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
[X] YES ☐ NO *If yes, return to and complete item 9 a-d.*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 12 / 09 / 2009

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE 10 01 2009

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a.
17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
☐ YES [X] NO $0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 847 0
2. 847 1
3. 847 2
4. 723 4

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From	To	B Place of Service	C EMG	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I I.D. QUAL.	J RENDERING PROVIDER ID. #
10 01 09	10 01 09	11		99205		1	250.00	1		NPI	1104973007
10 05 09	10 05 09	11		98941		1,2,3,4	75.00	1		NPI	1104973007
10 06 09	10 06 09	11		97010	59	1	35.00	1		NPI	1104973007
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25. FEDERAL TAX I.D. NUMBER SSN EIN
205918486 ☐ [X]

26. PATIENT'S ACCOUNT NO.
00001047

27. ACCEPT ASSIGNMENT?
[X] YES ☐ NO

28. TOTAL CHARGE
$545.00

29. AMOUNT PAID
$98.56

30. BALANCE DUE
$446.44

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
DAVID KATZ
SIGNED DC 12/09/2009

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
UNIVERSAL HEALTH GROUP, INC
26561 W. 12 MILE ROAD
SOUTHFIELD MI 48034
1588832653

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE PHONE #
UNIVERSAL HEALTH GROUP, INC.
5761 WEST MAPLE ROAD
WEST BLOOMFIELD MI 48322 248 626-6892
1588832653

whcfa150

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(13)

UHG-DET

DATE: 12/9/2011

DAILY TREATMENT FORM (TI) CHIROPRACTIC

DOA: 11/29/2011

DOB: 4/8/58

PATIENT NAME LAST: Redacted FIRST: Redacted

SUBJECTIVE: SEVERITY SCALE 1-10 (EXCRUCIATING) Type of complaint: L=left R=right W=weakness N=numbness T=tingling S=sharp A=achy D=dull B=burning C=constant F=frequent O=occasionally

____ HEAD	____ FACE	____ JAW	7/10 NECK	7/10 UPPER BACK
____ MIDBACK	8/10 LOWBACK	____ SHOULDER	____ ARM	____ WRIST
____ HAND	____ BUTTOCK	____ HIP	7/10 (lat) THIGH numbness	____ KNEE
____ LEG	____ ANKLE	____ FOOT	____ CHEST	____ ABDOMEN

NOTES: pt has radicular (P) from LB that goes down both lat thigh as numbness / into feet as numbness

OBJECTIVE: FIXATED SEGMENTS: C1/C2/C3/(C4/C5/C6/C7)/T1/T2/T3/(T4/T5)/(T6/T7/T8/T9)/T10/T11/T12/L1/L2/(L3/L4/L5)/S/RSI/LSI

PALPATION FINDINGS: L=left R=right T=tenderness S=spasm

L R T S Suboccipitals

L R T S Erector spinae

L R (T)(S) Posterior cervicals

L R T S Quadratus lumborum

L R (T)(S) (Trapezius)

L R T S Piriformis

L R (T)(S) Paraspinals

CMT

NOTES: ____

ASSESMENT: [x] First visit [ ] Guarded [ ] Continue - no change [ ] As expected [ ] Exacerbation of condition

[ ] Mild improvement [ ] Moderate improvement [ ] Other: ____

(1st exam + consult)

Adjustment: OCC/C1/C2/C3/C4/C5/C6/C7/T1/T2/T3/T4/T5/T6/T7/T8/T9/T10/T11/T12/L1/L2/L3/L4/L5/S/RSI/LSI

Extra Spinal: L/R shoulder L/R elbow L/R wrist L/R hand L/R knee L/R ankle foot Other: ____

NOTES: ____

PROGRESS/TREATMENT PLAN: Goals: reduce symptoms, increase functional capacity and return to normal activities of daily living

[x] THERAPEUTIC PHASE 1: Acute inflammatory, reduce inflammation, muscle spasm and pain

[ ] THERAPEUTIC PHASE 2: Repair and remobilization: functional scar formed and increase pain-free ROM

[ ] THERAPEUTIC PHASE 3: Remodeling and rehab: increase coordination, strength, ROM, endurance and work capacity

Tx schedule: [ ] daily [ ] 3x/wk [ ] 2x/wk [ ] 1x/wk [ ] 2 wks [ ] 3 wks [ ] monthly [ ] cont. Tx plan Massage: [x] 0 [ ] 1 [ ] 2 per wk/mo

NOTES: No tx schedule set yet; 1st exam/Consult/X-rays

SERVICES OR SUPPLIES RENDERED

Pt. Init.	NEW PATIENT EXAM	Pt. Init.	MODALITIES	Pt. Init.	X-RAY EXAMINATION	Pt. Init.	MISCELLANEOUS SERVICES
	09---99201---Brief		20---97010---Hot/Cold Pack		50---72010---Full spine AP/lateral		80---95999---Neurologic exam
	10---99202---Limited		21---97012---Mechanical Traction		51---72020---Single view		81---99080---Narrative rep
ACA	11---99203---Moderate		MANIPULATION TREATMENT	ACA	52---72040---Cervical 2 or 3 views		82---L3020---Foot insert molded
	12---99204---Extensive		30---98940---Adj 1-2 areas		53---72050---Cervical 4 views		83---L0625---Lumbar support
	13---99205---Comprehensive		31---98941---Adj 3-4 areas		54---72052---Cervical complete		84---L0120---Cervical foam collar
	ESTABLISHED PATIENT EXAM		32---98942---Adj 5 or more	ACA	55---72070---Thoracic 2 views		85---E0190---Position cushion/pillow
	15---99211---Brief		33---98943---Extraspinal	ACA	56---72100---Lumbar 2 or 3 views		86---97760---Orthotic fitting
	16---99212---Limited		THERAPEUTIC TREATMENT		57---72110---Lumbar 4 views		87---99002---Orthotic mailing
	17---99213---Moderate		40---97110---Therapeutic exercise		58---72120---Lumbar bending		
	18---99214---Extensive				59---72170---Pelvic 1 or 2 views		
	19---99215---Comprehensive				60---72202---Sacrum 3 views		

CPT CODE (98941): This is a manual spinal adjustment of up to 4 regions. Performed by hand (full spine). Thompson Drop Technique which the patient is adjusted by hand and the table drops from underneath the patient or Activator Technique in which a handheld instrument is used to adjust the patient. These adjustments remove vertebral fixations (subluxations) and realign the vertebrae of the spine.

CPT CODE (97010-59): Hot/Cold pack used to relax the tissue. It mobilizes edematous fluid, increased blood flow and reduces muscle spasms

CPT CODE (97012-59): Intersegmental Mechanical Traction. Each vertebra is tractioned out separately. This improves the biomechanics of the vertebral structure. In doing so it helps promote the return of the normal/natural spinal curvature.

Referred To/For: ____

DISCLOSURE AND ACKNOWLEDGEMENT

I attest to the fact that the above services were rendered and they were explained to me and I agree and give my complete informed consent to continue as the doctor feels necessary. I am aware my file is available for review u Redacted

Maddhere D.C. [signature]

Treating physician: (print) and signature

Patient/Guardian signature

SF0151261?

UNIVERSAL HEALTH GROUP-DET

U11

Physical Examination

☑ Initial exam ☐ Re-exam

Patient Name (last): Redacted First: Redacted Age: ______ ☑ Male ☐ Female

Height: 5'11" Weight: 150 lb
Posture:
Gait:
Skin (bruising, scars):
Other:

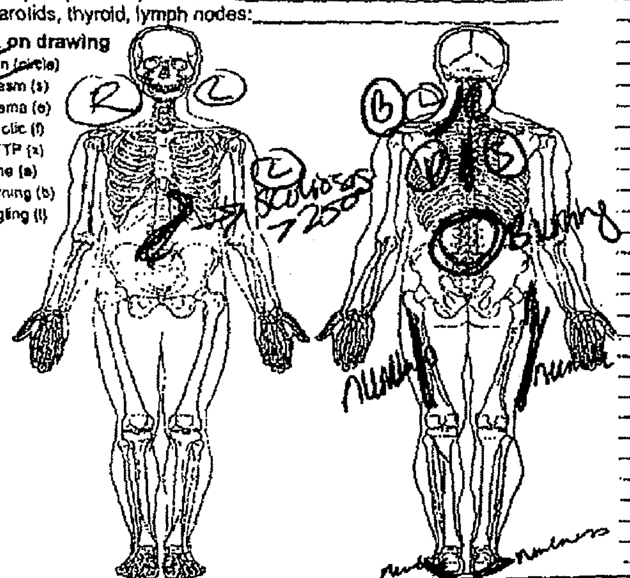
Sensation ☑ DNP	L	R
Light touch		
Sharp/dull		
Vibration		

Reflexes (0-5) ☑ DNP	L	R
Biceps (C5)(musculocutaneous)		
Brachioradialis (C6)(radial)		
Triceps (C7)(radial)		
Patellar (L4)(femoral)		
Medial hamstring(L5)(sciatic)		
Achilles (S1)(tibial)		
Babinski		
Other:		

CHI ☑ WNL
☐ Headaches ☐ Dizzy
☐ Blurred vision ☐ Sleep disturbance
☐ Tinnitus ☐ Memory loss
☐ Nausea/vomiting ☐ Photosensitivity

Palpation: ☑ WNL
☐ Skin, temperature, moisture:
☐ Parotids, thyroid, lymph nodes:

Mark on drawing
☑ pain (circle)
☑ spasm (s)
☐ edema (e)
☐ fibrotic (f)
☐ MFTP (x)
☐ ache (a)
☐ burning (b)
☐ tingling (t)



Spinal Palpation
C0, C1, C2, C3, C4 ×, C5 ×, C6 ×, C7 ×, T1, T2, T3, T4 ×, T5 ×, T6 ×, T7 ×, T8 ×, T9, T10, T11, T12, L1, L2, L3, L4 ×, L5 ×, S1 ×, Co, SI

Orthopedic exam: ☐ WNL, ☐ other:

Motor (0-5) ☐ DNP	L	R
Resisted neck ROM (C1-C4)	3	3
Shoulder elevation (CN XI, C3-C6)	5	5
Shoulder abduction (C4-C6)	3	5
Elbow flexion (C5-C6)	5	5
Elbow extension (C6-C8)	5	5
Wrist/finger flexion (C7-T1)	5	5
Wrist/finger extension (C6-C8)	5	5
Hip flexion (L1-L3)	3	3
Knee extension (L2-L4)	3	3
Knee flexion (L4-S1)	5	5
Plantar flexion (L5-S2)	5	5
Dorsiflexion (L4-L5)	5	5
Other		

Functional ☐ DNP	
Heel walk (L3, L4, L5)	+
Toe walk (S1)	+
Tandem Romberg	WNL
Romberg	WNL
Other:	

trouble sleeping due to pain

Cervical ☐ WNL		L	R
Compression		+	
Maximal compression		+	+
Distraction		+	with
PROM		+	+
Shoulder Depress		+	+
Soto Hall/Brudzinski			
Flexion (45°)	w/p	↓	
Extension (55°)	w/p	↓	
Lateral flexion (45°)	w/p	↓	↓
Rotation (70°)	w/p	↓	↓

Lumbar ☐ WNL		L	R
Kemp's test		⊕	⊕
SLR passive, active	@ 80°	⊕	⊕
Braggard's		⊕	⊕
Patrick's (FABERE)			
Thomas/Gaenslen's			
Valsalva		⊖	⊖
SI distraction/compression			
Flexion (90°)	w/p	↓	
Extension (30°)	w/p	↓	
Lateral flexion (20°)	w/p	↓	↓
Rotation (30°)	w/p	↓	↓

NOTES: Pt was the driver in a vehicle going 35-40mph going E on Grand River Ave, when another vehicle darted out from a side street and hit (M) Mr Anderson hit the other vehicles on the passenger side. The entire front of his vehicle was crushed as a result of impact.

DATE: 12/9/2011

DR: [signature]

UNIVERSAL HEALTH GROUP-DET U12

DIAGNOSIS FORM

☑ INITIAL EVALUATION ☐ RE-EVALUATION

PATIENT NAME (Last): Redacted (First): Redacted

✓	ICD-9	Description
		BCBS CODES
	719.41	Pain in joint, shoulder
	719.46	Pain in joint, lower leg
	728.5	Pain in limb
	786.50	Chest pain, unspecified
	789.07	Abdominal pain, generalized
	840.9	Sprain, shoulder and upper arm
	841.9	Sprain, elbow and forearm
	842.00	Sprain, wrist
	842.10	Sprain, hand
	843.9	Sprain, hip and thigh
	844.9	Sprain, knee and leg
	845.00	Sprain, ankle
	845.10	Sprain, foot
	846.9	Sprain and strains, shoulder
	847.0	Sprain and strains, neck
	847.1	Sprain and strains, thoracic
	847.2	Sprain and strains, lumbar
	847.3	Sprain and strains, sacrum
	847.4	Sprain and strains, coccyx
	848.1	Sprain, jaw
	848.5	Sprain, pelvis
	920	Contusion, face, scalp, neck
	924.00	Contusion, thigh
	924.01	Contusion, hip
	307.81	Tension Headaches
	346.90	Migraine, unspecified
	368.10	Blurred vision (subjective)
	368.13	Photosensitivity (visual discomfort)
	388.30	Tinnitus, unspecified
	524.60	TMJ disorders, unspecified
	780.4	Dizziness, vertigo and giddiness
✓	780.50	Sleep disturbance, unspecified
	780.79	Fatigue
	780.93	Memory loss
	782.0	Disturbance of skin sensation
	784.0	Headache
	787.0	Nausea/vomiting
	959.01	Head injury, unspecified
		Other

✓	ICD-9	Description
		BCBS CODES
✓	839.00	Closed dislocation cervical vertebra, unspecified
✓	839.20	Closed dislocation lumbar vertebra
✓	839.21	Closed dislocation thoracic vertebra
✓	839.42	Closed dislocation sacrum vertebra
		MEDICARE CODES
	739.0	Subluxation, Head region (occipitocervical)
✓	739.1	Subluxation, Cervical region
✓	739.2	Subluxation, Thoracic region
✓	739.3	Subluxation, Lumbar region
✓	739.4	Subluxation, Sacral region
	739.5	Subluxation, Pelvis region
	721.0	Spondylosis, cervical w/o myelopathy
	721.2	Spondylosis, thoracic w/o myelopathy
	721.3	Spondylosis, lumbar w/o myelopathy
	721.90	Spondylosis, unspecified w/o myelopathy
	722.4	Degeneration of cervical disc
	722.51	Degeneration of thoracic disc
	722.52	Degeneration of lumbar disc
	722.56	Degeneration of unspecified disc
	722.90	Disc disorder, unspecified region
	722.91	Disc disorder, cervical region
	722.92	Disc disorder, thoracic region
	722.93	Disc disorder, lumbar region
	723.0	Spinal stenosis, cervical
	724.00	Spinal stenosis , unspecified
	724.01	Spinal stenosis, thoracic
	724.02	Spinal stenosis, lumbar
✓	723.1	Cervicalgia
✓	724.1	Pain, thoracic spine
✓	724.2	Lumbago
	724.3	Sciatica
	723.4	Radiculitis, cervical/brachial NOS
✓	724.4	Radiculitis, thoracic or lumbosacral (unspecified)
✓	724.5	Backache (unspecified)
	728.4	Laxity of ligament
✓	728.85	Spasm of muscle
	729.1	Myalgia and myositis (unspecified)
		Other

Doctor Name (print): Andrea Nadolski Signature: [signature] Date: 12/9/2011

SP01519813

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

STATE FARM INSURANCE
PO BOX 661023
DALLAS TX 75266

CARRIER

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22070L262

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

6. PATIENT STATUS: Single Married Other X

7. INSURED'S ADDRESS (No., Street): Redacted

City: Redacted State: Redacted

Zip Code: Redacted Telephone (Include Area Code): Redacted

Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous): YES NO X

b. AUTO ACCIDENT? YES X NO PLACE (State): MI

c. OTHER ACCIDENT? YES NO X

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH: Redacted SEX: M X F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

SECOND FOLD

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 12 12 11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 11 29 11

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: ANDREA S MADHERE DC

17a

17b. NPI 1154553394

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 7231 7241 7242 7244 7245 72885

20. OUTSIDE LAB? YES NO X $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 739.1
2. 739.2
3. 739.3
4. 739.4

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 09 11	12 09 11	11		99203	25	1234	225 00	1		NPI	1154553394
2 12 09 11	12 09 11	11		72100		1234	150 00	1		NPI	1154553394
3 12 09 11	12 09 11	11		72070		1234	150 00	1		NPI	1154553394
4 12 09 11	12 09 11	11		72040		1234	125 00	1		NPI	1154553394
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 205918486 X

26. PATIENT'S ACCOUNT NO.: 42550C78946

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 650 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 650 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ANDREA S MADHERE DC

SIGNED 01 25 12 DATE

32. SERVICE FACILITY LOCATION INFORMATION

UNIVERSAL HEALTH GROUP
2888 W GRAND BLVD
DETROIT MI 48202-2612

a. 1588832653 b.

33. BILLING PROVIDER INFO & PH. # (248)8894580

UNIVERSAL HEALTH GROUP
2000 TOWN CENTER SUITE 625
SOUTHFIELD MI 48075-1135

a. 1588832653 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SF151201212

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record," published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn. PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS